Incorporating Value-Based Care into Oncology Practice

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Disclosure of Conflicts of Interest

Susan M. Escudier, MD, FACP, has no relevant financial relationships to disclose.

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Cancer Care Economics

- Cancer is one of the most common and devastating diseases in the United States.
- Over 1.9 million people are estimated to be diagnosed with cancer in 2022.
- With over 600,000 deaths in 2022, cancer will be the second leading cause of death
- Leading cause of death for males and females aged 60 – 79 years old, the majority of whom are Medicare patients.
- Under traditional Medicare fee-for-service (FFS), oncology providers receive separate payments for each item or service furnished to a beneficiary while undergoing cancer treatment.
- Traditionally, cancer care has focused on treating the disease and not the person, which can result in fragmented care

What is Value Based Care?

- Measured improvement in health care outcomes related to the cost of improvement.

- Cost reduction, patient satisfaction and quality improvement are often included, but value should be based on patient health outcomes.

VALUE = QUALITY/COST

QUALITY DEFINITION

- Employers
  - Employee retention, worker productivity
- Insurance companies
  - Client satisfaction, returns to stockholders
- Physicians
  - Treatment guidelines, expert opinion, regulatory agencies
- Patients
  - Health quality, clinic experience, meeting of information needs

VALUE = QUALITY/COST

COST DEFINITION

- Employers
  - Cost for insurance, lost productivity
- Payers
  - Healthcare costs (loss), administrative costs
- Physicians
  - Clinic costs, time
- Patients
  - Out of pocket expenses, time off work, travel costs
  - Physical and emotional cost
- Total cost of care should include all the above

Value Based Care Examples

VALUE/COST	INTERVENTION
Low value/low cost	Antibiotics for a viral respiratory infection
Low value/high cost	Surveillance scans in early breast cancer
High value/low cost	Nursing follow up phone call for chemotherapy patients
High value/high cost	Immunotherapy in melanoma treatment

Oncology Care Model

- Established to improve the effectiveness and efficiency of oncology care for Medicare beneficiaries.
- OCM payment model aligned financial incentives to support improvement efforts in care coordination, appropriateness of care, and access for those undergoing chemotherapy.
- Practices were paid monthly enhanced oncology services payments for six-month periods on treatment (MEOS)
- Practices that met the Medicare goals were then allowed to participate in two-sided risk for non-drug related costs
- Practices shared savings and shared losses

OCM Goals
Comprehensive, Coordinated Cancer Care

- Access and continuity
- Care Coordination
- Care Planning and Management
- Patient and Caregiver Engagement
- Team-Based Care

OCM Goals
Continuous Improvement Driven by Data

- Data-driven quality improvement (QI)
  - employs the use of a balanced set of measures with a strong evidence base to inform change and practice transformation
  - identify and understand practice variation
  - provide clinical decision support
  - monitor and sustain successful practices.
- Evidence-Based Medicine

OCM Quality Requirements for Performance Based Payments

Communication & Care Coordination

- Hospital Admissions
- ED Visits
- Hospice Admissions >/=3 Days

Person & Caregiver Experience

- Pain Scores
- Depression Screening
- Patient Survey

Clinical Quality Care

- Adjuvant hormones in high risk prostate cancer
- Timely adjuvant chemotherapy in colon cancer
- Timely combination chemotherapy in hormone negative breast cancer
- Trastuzumab in State I-III her2+ breast cancer
- Adjuvant hormones in breast cancer

Patient Safety

- Documentation of medications

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Improving Quality at Texas Oncology

NCCN Driven Treatment Pathways

- Standard of care
- Rapid updates

Shared Decision Making

- Physician derived plan for care
- Diagnosis, prognosis, toxicity and cost

Prognostic Modeling

- APEX, pain scores
- Appropriate patient and treatment selection

Enhanced Services

- Care coordination visits
- Genetic counseling
- Virtual APP clinics
- Social workers/support groups

Advanced Care Planning

- Patient driven values should determine level of care

Patient Satisfaction

- Surveys, ease of access, communication
- Navigating cancer program decreased callback times, improved symptom management

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Maintaining Quality

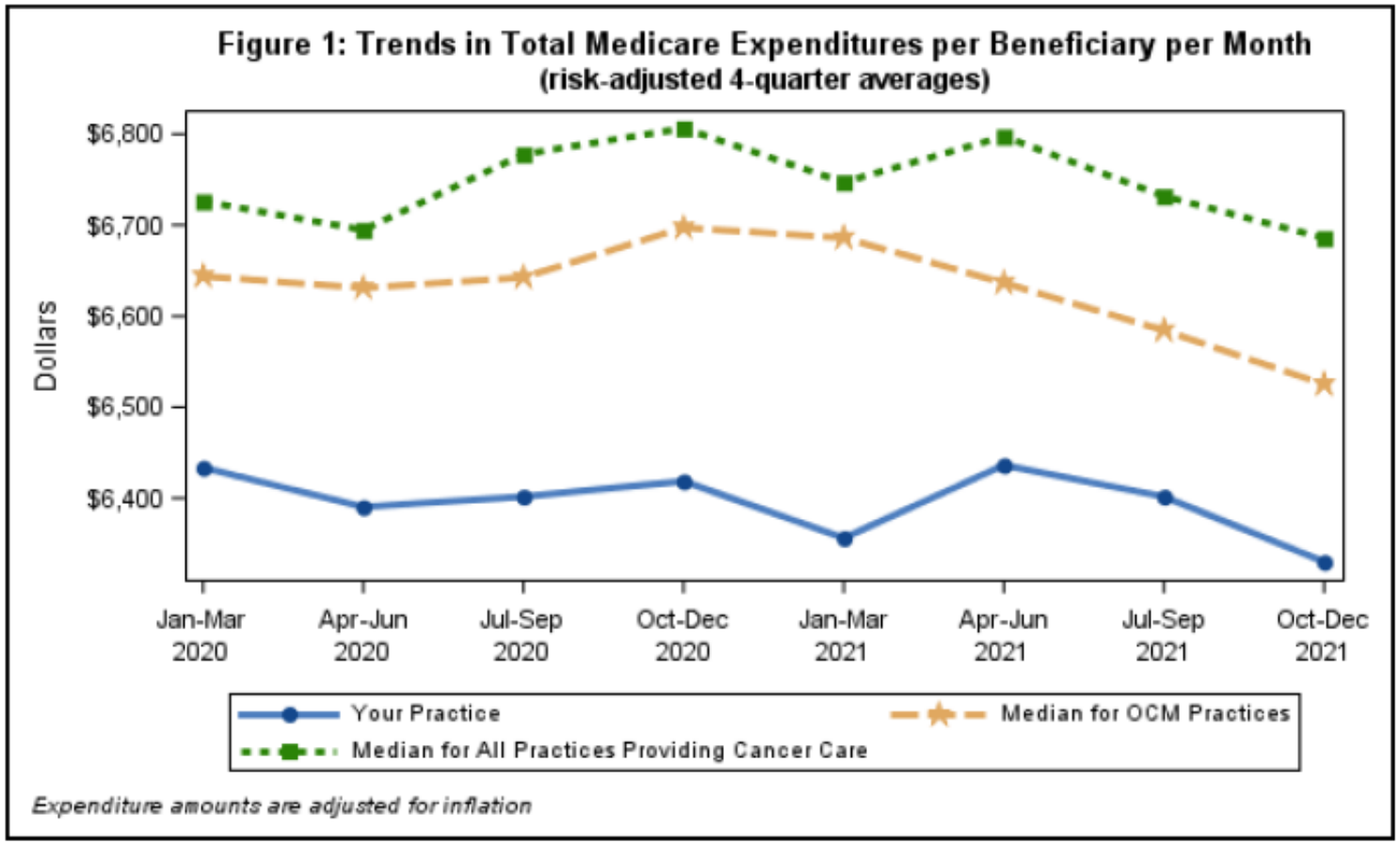
Physician-led Specialty Quality Committees

- Quality metric monitoring/national guidelines
- Periodic chart review
- Focused reviews
- Physician dashboards
- Identify quality improvement projects

Controlling Costs

- Clinical Pathways – better purchasing power with decreased variation, decreased waste and errors
- Dose banding and dose rounding when appropriate
- Biosimilars/generics integration reduces costs with no loss of efficacy
- Decrease of nursing/infusion time can reduce costs depending on the cost of the drug, i.e. SC vs IV, combined drugs
- Medication dispensing – integrated pharmacies eliminate unnecessary charges and more expensive drugs sometimes required by PBMs
- Hospital admission and ED visit reduction by enhancing clinic services

Total Cost of Care



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VBC Successes

OCM
(July 2016 to June 2021)

- Admissions dropped from 24.7% to 16.2%
- ED Visits dropped from 23.8% to 18.3%
- Average savings per patient episode increased 667% to an average savings of $2,2001 for total shared savings of $133.8M

CIGNA

- ED Visits dropped 30% from 789.5 visits per 1000 patients to 556 from Oct 2019 to September 2021

HUMANA

- Inpatient claims per patient dropped 15% from 7.9 claims per patient to 6.69 claims per patient from April 2019 to Sept 2021

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Lessons Learned TXO

Positives

- Net gain from OCM from MEOS, performance based payments, and QPP/APM less the increase in FTEs related to enrollment and billing, quality programs, coders, social workers and the cost fro nursing staff for enhanced symptom management.
- Net positive on 3 out of 4 commercial VBC programs
- HCC coders resulted in better capture of comorbidities and enhanced reimbursement

Negatives

- Harder to show improvements based on our past performances vs compared to national performance.
- Early adoptions of pharmacy strategies may not be repeatable, i.e. biosimilar substitution
- Improving on Admits/ED Visits post COVID has been difficult.
- Room for improvement in hospice utilization and decreasing chemotherapy utilization in the last 14 days of life

KEY FINDINGS FROM FINAL OCM EVALUATION REPORT

- OCM impact was small relative to the rapid increase in payments
- The relative reduction in Total Episode Payments (TEP) was concentrated in higher-risk episodes
- There were OCM impacts in Part A ($185) and B ($294) payments but not in Part D
- OCM resulted in net losses to Medicare totaling $377.1M
- OCM reduced TEP by $298 ($p<0.05$) relative to comparison episodes
- TEP increased substantially in both OCM and comparison episodes, but slightly less in OCM episodes ~1% of baseline episode payments
- TEP for higher-risk episodes, which made up about two-thirds of all episodes, averaged about $48,000, OCM reduced TEP by $487

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Shift in Value-based Care Programs

- Voluntary >> Mandatory
- Less Risk >> More Risk
- Increased focus on savings & cost of care
- Maintaining quality expectations
- Outcome-based measures & ePROs
- Bundled or episode-based models
- Population health & health equity
- Increased need for real-time analytics & visibility into cost
- Less to no upfront payment (e.g., MEOS, PMPM, etc.)

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Oncology VBC – Next Generation

- So what's next?

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Oncology Care Transformation - The Enhanced Oncology Model

Stated Purpose - Drive Transformation In Oncology care

- preserve or enhance the quality of care furnished to beneficiaries undergoing treatment for cancer
- reduce program spending under Medicare fee-for-service
- put the patient at the center of a care team that provides equitable, high-value, evidence-based care
- build on the lessons learned from the Oncology Care Model
- increase engagement of patients, oncologists, and other payers in value-based care and quality improvement
- improved care quality, equity, and health outcomes as well as achieve savings over the course of the model test.

Enhancing Oncology Model

- Participants will be incentivized to consider the whole patient and engage with them proactively, during and between appointments.
- CMS is testing an alternative payment model in which physician group practices
  - take on financial and performance accountability for episodes of care surrounding chemotherapy administration
  - Have the opportunity to bill for provision of Enhanced Services furnished to beneficiaries
  - Are encouraged to promote health equity, improve beneficiaries' health outcomes and reduce costs

EOM Cancer Types Included

Seven cancer types for beneficiaries undergoing systemic chemotherapy vs 21 for OCM

- breast cancer
- chronic leukemia
- small intestine/colorectal cancer
- lung cancer
- lymphoma
- multiple myeloma
- prostate cancer.
- excludes low risk hormone only treated breast and prostate cancer patients
- about 45% of prior OCM patient population

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Enhancing Oncology Model (EOM): Beneficiary Eligibility

- Diagnosed with included cancer type
- Receives an initiating cancer therapy
- Qualifying E&M service from PGP during the episode
- Eligible for Medicare Part A and enrolled in Medicare Part B for entirety of episode
- Not enrolled in any Medicare managed care organization at any point during episode
- Not diagnosed with End Stage Renal Disease (ESRD) at any point during episode
- Medicare must be their primary payer for entirety of episode

Beneficiary Attribution:

- 1st E&M after Chemo initiation *and*
- 25% of Cancer E&M services
- Tie: Plurality

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EOM: Monthly Enhanced Oncology Services (MEOS)

July 26: CMMI EOM Payment Webinar

Option to bill for Monthly Enhanced Oncology Services (MEOS) payment for Enhanced Services provided (PRA)

- Base MEOS payment amount will be **$70 per EOM beneficiary per month**
  - Included in participants' total cost of care responsibility, like OCM
- MEOS Payment for **dual-eligible** (Medicare and Medicaid beneficiaries) **additional $30 per month, total of $100**
  - Additional $30 will *not be included* in participants' total cost of care responsibility

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EOM: Practice Redesign Activities (Enhanced Services)

Provide 24/7 access to appropriate clinician with real-time access medical records	Provide patient navigation	Document care plan containing 13 components of IOM Care Management Plan	Treat with therapies consistent with nationally recognized clinical guidelines
Use Certified EHR Technology (CEHRT)	**Identify beneficiary health-related social needs using a health-related social needs screening (HRSN) tool**	**Gradual implementation of electronic Patient Reported Outcomes (ePROs)**	**Utilize data for continuous quality improvement (CQI) & Health Equity Plan**

Provide for 30 days prior and 30 days after episode ends

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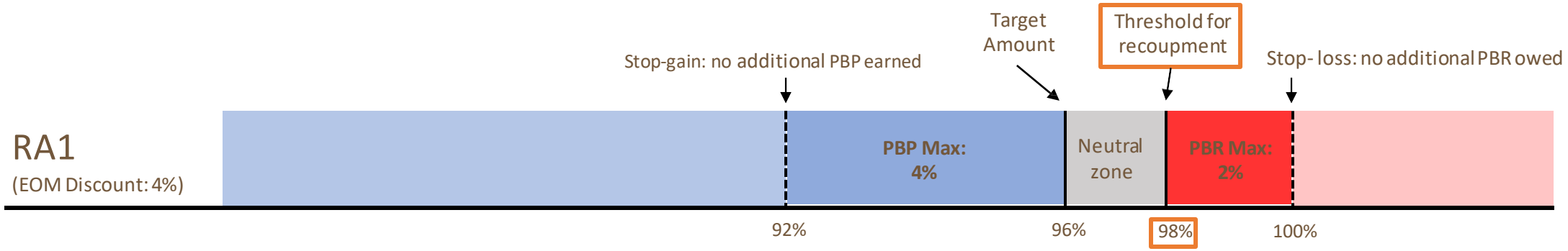
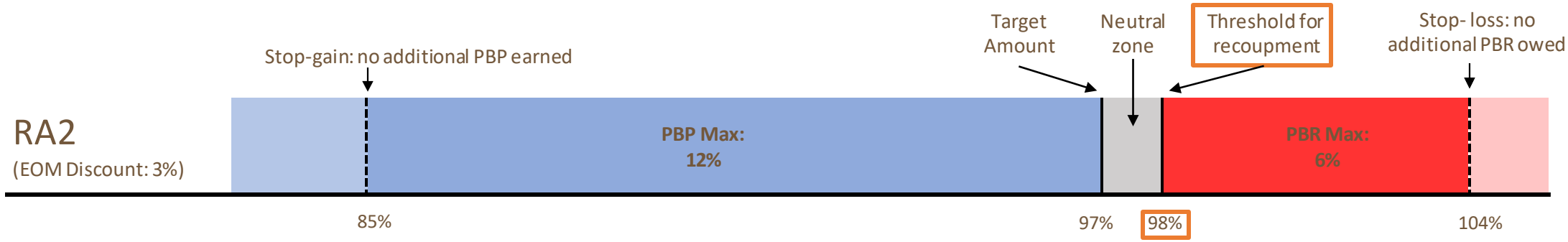
Enhancing Oncology Model (EOM): Risk Models





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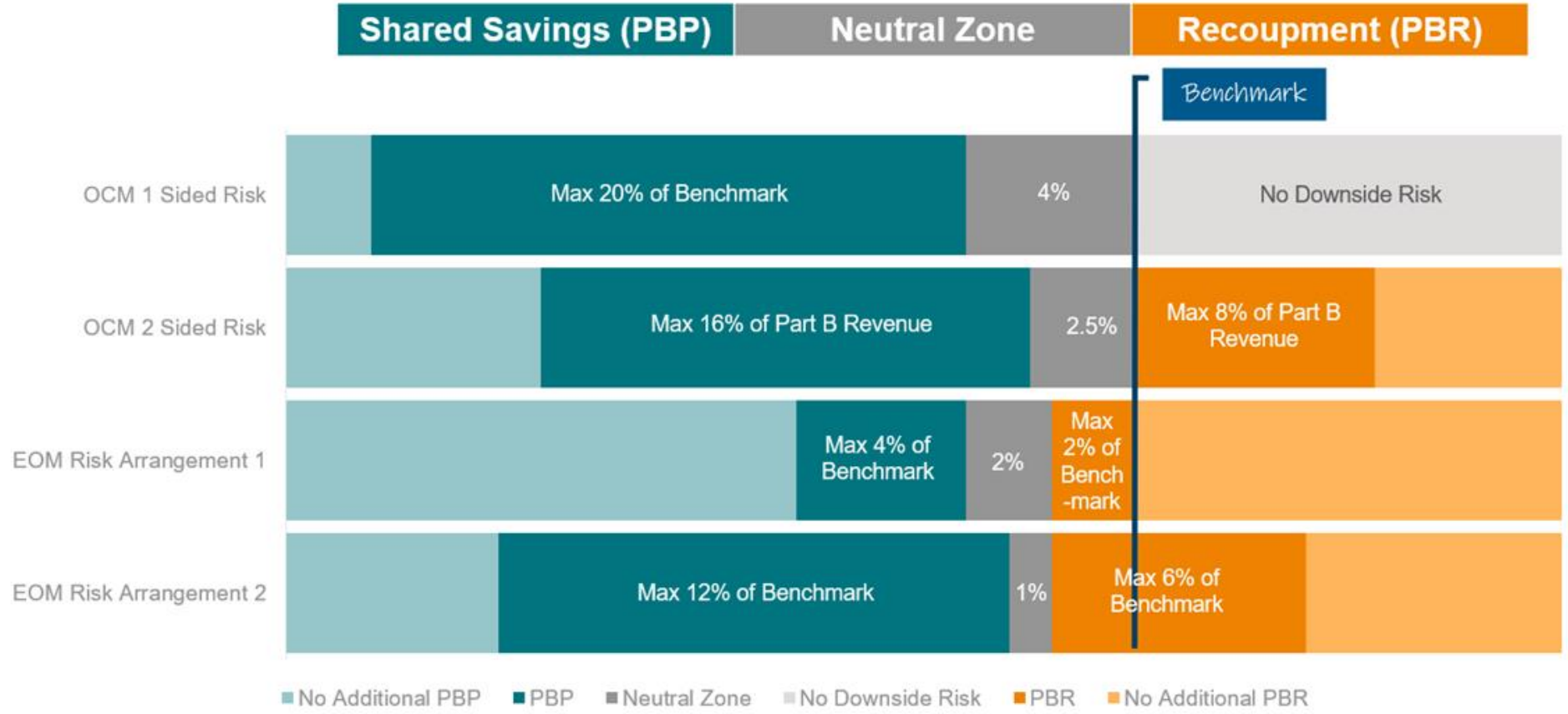
Risk Model Overview

3 Major Payment Zones To Consider



Reward and Risk comparable to OCM

Taking risk is mandatory in EOM

Benchmark Amounts

Benchmarks for the level of total cost of care are used for calculating savings based on historical billing

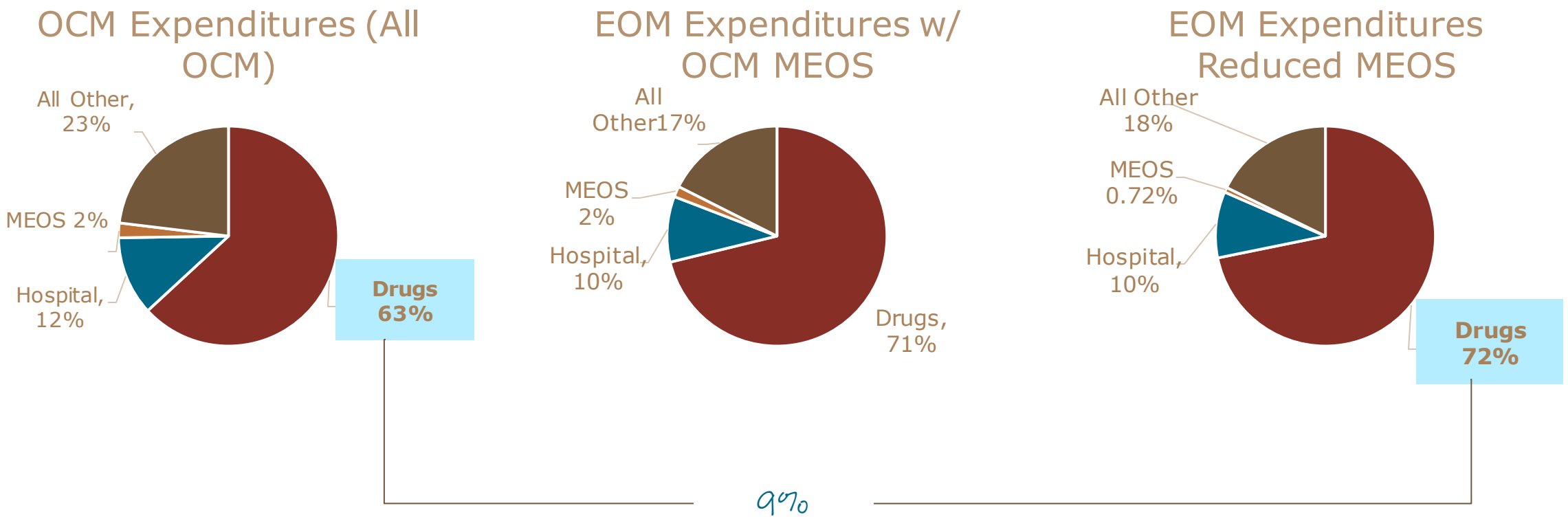
- Separate price prediction model for each included cancer type.
- Experience adjuster accounting for regional and participant-specific variation in the cost of oncology care
- Clinical adjusters based on clinical and staging data
- Cancer type-specific trend factors adjusting for inflation and other cancer type-specific changes in spending patterns occurring across the oncology field as a whole
- Cancer type-specific novel therapy adjustments to increase the benchmark price for episodes of a given cancer type if an EOM participant has a high share of expenditures within that cancer type for newly FDA-approved oncology drugs.

Higher Benchmark and Higher Costs

- EOM benchmark for all included cancers is 1.5X OCM
- Benchmark drivers are cancer types, trend factor, HCC, and patient mix
- Hierarchical condition category coding is a risk-adjustment model designed to estimate future health care costs for patients.
- Expenditures for all included cancers is 1.4X OCM
- Higher expenditures driven by drug expense, inpatient expenses, cancer types

The Network Level EOM Impact Findings

Drugs represent a higher portion of the expenditures



Greater control over Drug Expenditures; More impact of Drug Initiatives

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PRA: Health-related Social Needs (HRSN) Screening

- HRSN Screening tools include, but not limited to:
  - ✓ NCCN Distress Thermometer
  - ✓ Accountable Health Communities Screening Tool
  - ✓ PRAPARE Tool
- Screen for, at a minimum, 3 HRSN domains:
  - Transportation
  - Food insecurity
  - Housing instability

All HRSN domains:

- ✓ Transportation
- ✓ Food insecurity
- ✓ Housing instability
- Utility help needs
- Financial strain
- Employment
- Family and community support
- Education
- Physical activity
- Substance use
- Mental health
- Disabilities

Why?

Encouraging EOM participants to develop community partnerships to address identified needs in patient navigation

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NCCN Guidelines Version 1.2022
Distress Management

NCCN Guidelines Index
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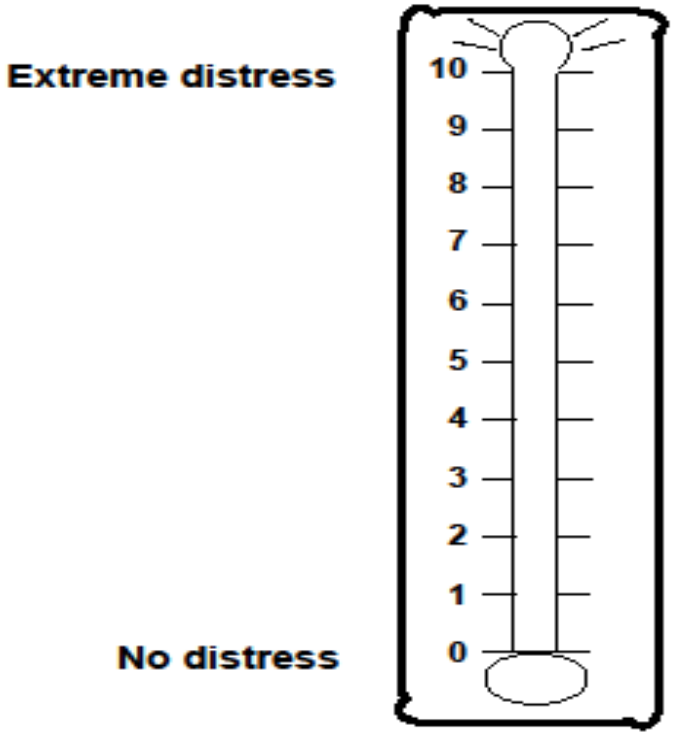
NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.



PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns
- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns
- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children

Practical Concerns
- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Work
- ❑ School
- ❑ Housing
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns
- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns:

_____

_____

_____

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

PRA: ePROs

- Collect electronic patient-reported outcomes (ePROs) data from patients, including an HRSN domain
  - To start in model year three (2025-2026)
- Data collected directly from the patient, without amendment or interpretation of the patient's response
- No specific tool required but must address each of the following domains:
  - ✓ **Symptoms and/or toxicity** (e.g., frequency, severity, activity interference, presence/absence)
  - ✓ **Functioning** (e.g., physical functioning, role functioning)
  - ✓ **Behavioral health** (e.g., psychosocial functioning, anxiety, depression, other behavioral health conditions)
  - ✓ **Health-related social needs** (e.g., financial toxicity, transportation, food insecurity)

Why?

- better identification of patients' needs in provider area
- improved patient-provider communication
- patient satisfaction
- decreased ED utilization

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PRA: CQI & Health Equity Plan

- EOM participants required to establish health equity plan as part of continuous quality improvement (CQI) efforts
  - To identify and monitor the disparities for their beneficiary population
  - Develop evidence-based strategies to address specific health disparities identified in their patient population
- Health equity plans would not be used for determinations within EOM, used as a tool

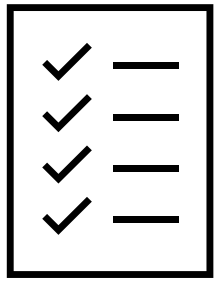
Why?

- Important for EOM participants to identify and monitor where disparities exist in *their* EOM beneficiary population and use data to support evidence-based strategies aimed at addressing health disparities identified and advancing health equity

EOM: Quality

- Three submission types
  - EOM participant-reported
  - Claims-based
  - Patient experience survey quality measures
- Measure focus
  - Patient experience
  - Avoidable acute care utilization
  - Management of symptoms toxicity
  - Management of psychosocial health
  - Management of end-of-life care
  - Outcomes-based measures
    - Some collected from patients, minimize EOM participant reporting burden
- Measures set to be similar OCM, will update quality measures as new measures emerge, including a focus on health equity

8/20: CMMI EOM Quality Strategy Webinar



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EOM: Aggregate Quality Score

EOM Participant earning high AQS:

- Maximize EOM participant's PBP is eligible to receive; or
- *Reduce amount of PBR owed to CMS*, if the EOM participant's performance period expenditures exceed threshold for recoupment (98 percent of the benchmark)

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Enhancing Oncology Model (EOM): Other Payers

- ✓Multi-payer model
  - Private payers, Medicare Advantage plans, and state Medicaid agencies are invited to apply for the model
    - Elements for alignment
      - Health Equity
      - Data Sharing
      - Payment Approach
    - Must partner with EOM Participant for duration of model
- ✓Encourage payers to have the same approach for both Traditional Medicare beneficiaries and patients with other health insurance

THANK YOU

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